

Case Number:	CM13-0027373		
Date Assigned:	11/22/2013	Date of Injury:	10/01/2008
Decision Date:	03/17/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 45-year-old male who reported an injury on 10/01/2008 that ultimately resulted in a lumbar fusion at the L4-5. The patient was treated postsurgically with medications, physical therapy, and injection therapy. The patient's most recent clinical evaluation included tenderness to palpation of the lumbar musculature with limited range of motion secondary to pain. The patient also had right piriformis tenderness and a positive right FAIR test. The patient's diagnoses included status post lumbar fusion at the L4-5 level with transitional lumbar anatomy and multilevel spondylosis. The patient is also diagnosed with depressive disorder, obstructive sleep apnea, and gastritis. The patient's treatment plan included replacement of a home interferential unit with H-Wave, as the patient's old unit was reportedly non-functional, and continuation of medication management.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Replacement Interferential Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS Page(s): 118.

Decision rationale: The request for the replacement interferential unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously had this type of unit. It is also noted that the previous unit is no longer functional. California Medical Treatment Utilization Schedule recommends the purchase of this type of equipment be based on a trial with documentation of functional benefit. A replacement unit would also need to be supported by functional benefit as a result of the previous unit. As the clinical documentation does not specifically identify any functional benefit or symptom relief as a result of the prior interferential unit, the replacement of that unit would not be medically appropriate or necessary.